



For office use only

### General Neurology Referral Form

Thank you for choosing Southern Ontario Epilepsy Clinic. To best serve you within a reasonable time frame please have this form filled out completely and legibly. Please send the necessary information along with the referral so that it can be appropriately triaged by. Dr. Bercovici.

**PLEASE FAX COMPLETED REFERRAL FORM TO 416-620-7633**

**Patient Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Health card number: \_\_\_\_\_ Version Code: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Telephone #: Mobile: (\_\_\_\_) \_\_\_\_\_ Home/Business: (\_\_\_\_) \_\_\_\_\_

**Reason for Referral**

Reason for Referral: \_\_\_\_\_

How long as this being ongoing for: \_\_\_\_\_

Level of urgency  
 Next available                       Semi-urgent\*                       Urgent\* (please call our office)

\*Please state reason for urgency: \_\_\_\_\_

Medications: \_\_\_\_\_

Past Medical history \_\_\_\_\_

\_\_\_\_\_

**Referring Physician information**

Name: \_\_\_\_\_ (MD / NP) Billing # \_\_\_\_\_

Address: \_\_\_\_\_

Telephone # (\_\_\_\_) \_\_\_\_\_ Fax # \_\_\_\_\_